NORTH DAKOTA DEPARTMENT OF HEALTH

Family Planning Program

REQUEST TO RECEIVE FAMILY PLANNING SCREENING SERVICES

Name _____Chart No: _____

The Family Planning screening services may include:

* Routine Lab testing as indicated
* Pap smear
* Pregnancy test
* Physical examination & appropriate treatment
* STD (sexually transmitted diseases) testing
* Relevant education information/written Materials as appropriate

All tests plus any other records or communications will be kept confidential and only released with your written consent, except as required by law or third party pay contract.

I understand that my individually identifiable health information may be used or disclosed for treatment, to obtain payment for services provided, and as necessary for the operational of this clinic. These uses and disclosures are more fully explained in the Privacy Notice that has been provided to me, which I have had the opportunity to review.

I understand that the privacy practices described in the Privacy Notice may change over time, and that I have a right to obtain any revised Privacy Notice if I request.

I understand I have a right to request to restrict how my health information is used or disclosed.

I hereby authorize the use or disclosure of my individually identifiable health information to the North Dakota Department of Health, Family Planning Program. The specific information to be disclosed includes a listing of medical, laboratory, counseling, contraceptive and referral services received at each clinic visit. This information will be used for the purpose of monitoring and oversight of the program and federal reporting in accordance with program regulations.

I understand the above information and in accepting Screening Services I hereby assume full responsibility and hereby release the Family Planning Program and staff of any and all liability for any adverse results that may occur.

_____ _____

Client Signature Date

_____ _____

Family Planning Staff Witness Date